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ABSTRACT

Human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) have become a serious health threat to university students. This study evaluated a peer-led intervention program with university students to increase knowledge and attitudes of HIV/AIDS infection and transmission. Subjects were students (n=41) from an undergraduate psychology class (21 females and 20 males). For the intervention, two Peer Health Facilitators presented HIV/AIDS related information, led interactive activities, modeled ways to use condoms safely, and answered questions. A pretest/posttest questionnaire was administered immediately preceding and following the presentation to assess differential changes in HIV/AIDS related attitudes and knowledge. The results showed significant improvement from pretest to posttest. Appendices are: (1) "HIV/AIDS Flip Chart Outline"; (2) "STD Shuffle" (directions for conducting a classroom exercise); and (3) "Knowledge/Attitudes About HIV/AIDS Pre-Test Post-Test." Contains 22 references. (Author/RB)

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Effects of a Peer Health Facilitator HIV/AIDS Intervention with University Students

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Abstract

Human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) have become a serious health threat to university students. This study evaluated a peer-led intervention program with university students to increase knowledge and attitudes of HIV/AIDS infection and transmission. Subjects were students (N=41) from an undergraduate psychology class (21 females and 20 males). For the intervention, two Peer Health Facilitators (PHF's) presented HIV/AIDS related information, led interactive activities, modeled ways to use condoms safely, and answered questions. A pretest/posttest questionnaire was administered immediately preceding and following the presentation to assess differential changes in HIV/AIDS related attitudes and knowledge. The results showed significant improvement from pretest to posttest.

Background of the Problem

According to the Indiana State Department of Health (HIV/AIDS Surveillance Report, April 1, 1993), over 250,000 persons in the United States today have been diagnosed with Acquired Immunodeficiency Syndrome (AIDS). Although this disease started in the U.S. primarily in the gay male population, the epidemic is quickly spreading and is gaining speed in the heterosexual population, particularly those in the age range of 20-29. For this and other reasons, the Center for Disease Control (CC) had predicted that AIDS will soon be the number one killer of college students (quoted in the National AIDS Network Monitor, 1989, Winter).

College students are at risk for AIDS for a number of reasons. Many students are very sexually active, highly mobile, and in a developmental period of life where experimentation with a variety of sexual practices, such as bisexuality, is not uncommon (Katayama, 1987). According to several national studies, approximately 70% of women and 80% of men have engaged in sexual intercourse by 19 years of age (Eider, 1991). In fact, the average age among university students at which they had begun to have vaginal intercourse, was 17 years of age (Baldwin & Baldwin, 1988).

According to Katayama (1987), upon entering college, the sexual networks of young people suddenly expand; yet these same students are often very naive about the prevention of sexually transmitted diseases (STD's). Approximately 25% of North

American university students will have contracted some type of STD before they graduate from college (Hebert, Bernard, DeMan, & Farrar, 1989). In spite of the high risk of STD's, college students frequently report multiple sexual partners and low usage of condoms as a protective device.

The real risk for the college-aged population becomes evident if one examines the average latency period for the virus in relation to the age groups in which the largest number of cases have been reported. The prevalence of AIDS in the age groups 25 to 29 and 30 to 35, in conjunction with the average latency period of 8 to 10 years, probably puts the traditional college-age population in the midst of an age group at highest risk for infection (Cline & Engel, 1991).

These risk factors have become a reality according to the American College Health Association (ACHA). An early study completed by the ACHA through a cooperative agreement with the CC tested anonymous blood samples from college students at nineteen different college campuses in the U.S. Results of the study found one in 500 blood samples to be HIV infected (Wakalee-Lynch, 1989).

The only effective weapon today for preventing direct person-to-person transmission of HIV infection is education that may result in behavior that reduces exposure to the virus (Bell, Grissom, Stephenson, Frierson, Hunt, Lacefield, & Teller, 1990). However, dissatisfaction with the limited success of traditional educational methods has created a need for creative alternate

approaches to AIDS education targeted at young adults (Shulkin, Mayer, Wessel, Moor, Elder, & Franzi, 1991). One type of a creative approach is that of peer education.

Peer education, which means teaching people of the same age, has been around for many years (Anderson, 1976). Peer education programs are based upon the assumption that young people communicate with their peers, often passing along incomplete, distorted, or inaccurate information. The peer education movement tries to reverse this traditional pattern by training students to become equipped with factual information and communication skills (Steinhausen, 1998). Peer education is thought to be successful as perceived empathy and similar life experiences appear to provide the peer educator with an automatic advantage over professional counterparts (Sciacca & Seehafer, 1986).

In recent years, peer education has been used effectively as a part of college campus outreach programs to assist, advise, inform, and counsel students about health issues (Shulkin et al, 1991). Authority figures may have difficulty communicating to students about sexuality issues, possibly due to their own discomfort with the issue. Also, students may not perceive teachers or professionals as reliable or credible sources of sexual health information. Peer educators can use their position among students to make themselves credible messengers for risk reduction (Keeling, 1989).

Considerable evidence exists that peer teaching programs are an effective way of providing health education (National Institutes of Health, 1980). In some studies, peer-led programs were more effective than teacher-led programs and contributed to lower prevalence rates in smoking, drinking, and use of marijuana (Botvin, Baker, Renick, & Filazzalo, 1984). A study at a large state university in Southern California showed significant improvement among intervention subjects on knowledge, attitudes and behavior scales compared to a control group, after a peer-led AIDS intervention (Shulkin et al, 1991).

Florida Atlanta University conducted a similar study and the evaluation of the peer-led program showed increase of knowledge about HIV infection, as well as a high preference rate by the students for peer-led programs (Richie, Stenroos & Getty, 1990).

Some peer education attempts have not been successful. Peer educators can be seen as presumptuous "know-it-alls" who constantly intrude into the lives of their family, friends, neighbors and coworkers, under the guise that they are fully qualified experts in all matters of health and safety (Finn, 1981).

A review of the literature shows mixed findings regarding the HIV/AIDS related knowledge base of college students. According to Fennel (1991), a review of studies suggested some level of knowledge about AIDS among students, but misperceptions do still exist, especially in the area of how HIV is or is not transmitted. According to Richard Keeling (1991), a well known

and respected AIDS educator, studies show over and over again, that students, in general, have very good to excellent levels of knowledge regarding HIV.

Despite the mixed reviews about the level of knowledge which students possess regarding HIV/AIDS, the literature does support the fact that peer-led AIDS programs have added to the pre-existing level. If peer-led programs are an effective teaching tool, then AIDS knowledge should be greater following a peer-led presentation.

The general question behind this investigation was "How can AIDS education be enhanced to be more effective for the college-aged population?"

More specifically, the reason for this study was to investigate the problem "Can AIDS education be improved upon at the college level by the use of peers as instructors?"

The hypothesis investigated in this study was: There will be a significant, positive increase in AIDS knowledge among college students as a result of a peer-led educational intervention.

Methodology

Subjects. The subjects who participated in this study were 41 students enrolled in an introductory psychology course at Indiana State University. Of the 41 participants, there were 21 females and 20 males; 28 freshmen, 5 sophomores, 3 juniors, 4 seniors, and 1 graduate. The age range was demonstrated in the following breakdown: four 17 to 18 years of age; ten 19-20 years

of age; five 21-22 years of age; four 23-24 years of age; and nineteen who were 25 years of age or more. The psychology course in which the subjects were enrolled was randomly selected from 14 sections. All participants were volunteers.

Experimenters/Presenters. The experimenters/presenters included two student "Peer Health Facilitators" (PHF's), who were volunteer students who had completed 30 hours of training in accordance with American Red Cross guidelines. Training for the PHF's focused on the history and psychological basis of HIV infection and how to give presentations and answer questions. PHF's learned the technical and social skills necessary to avoid HIV infection and how to communicate these skills to their peers.

Intervention. In March, 1993, the two PHF's conducted a one-hour presentation before the psychology class. They presented AIDS information on the history of the disease, modes of infection and transmission, prevention methods, referral sources, testing information, and the importance of communication between partners. One third of the program was didactic and utilized an HIV/AIDS flip chart (see Appendix A). During the discussion, students commented frequently and asked a variety of questions. One third of the program was an interactive experience, the STD shuffle, which is an exercise designed to raise awareness of HIV transmission (see Appendix B). For the final third of the program, the PHF's demonstrated how to use a condom correctly by putting a condom on a model. Following their condom demonstration, the subjects were given the opportunity to

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roll condoms down their own fingers, demonstrating their skills in condom usage. At the conclusion of the program, free condoms and HIV/AIDS literature were distributed to all students.

Evaluation Instrument & Procedures. The dependent measure in this study consisted of a 43-item questionnaire developed by the American Red Cross (see Appendix C), and designed to measure knowledge and attitudes regarding HIV/AIDS. The questionnaire was administered as a pretest before the presentation and as a posttest after the presentation.

Before administering the pretest, the presenters gave the following instructions: "You have all received a Knowledge/attitudes about HIV/AIDS questionnaire form. Please read each item carefully and select the response which most nearly reflects your understanding and/or attitude. On questions 1-4 you will circle the correct response. On question 5-40 write the correct response, A (definitely true, B probably true), C (probably false), or D (definitely false), on the line preceding each item."

Following the presentation, participants were given new copies of the questionnaire, and given the following instructions:

"Please complete the Knowledge/attitudes about HIV/AIDS questionnaire once more, using the instructions given at the beginning of this presentation. This time, however, your responses should reflect the knowledge and attitudes you possess having witnessed the presentation."

The questionnaires were collected at this time and the subjects were thanked for their participation. All 41 subjects completed the pretest and posttest questionnaires. An informed consent was not used since survey completion implied consent. Names were not used on the questionnaires to ensure confidentiality.

Analysis. Each non-demographic and non-opinion item (32 items) on the questionnaires was scored on a four point scale, with one indicating the least amount of correct knowledge of HIV/AIDS, and four indicating the greatest amount of correct knowledge of HIV/AIDS. The responses on each questionnaire were totaled, yielding a score ranging from 32 to 128 for each participant.

Because the participants' pretest and posttest questionnaires were not matched, the questionnaires were simply grouped together as pretest or posttest, collapsing across the participants. Group means were then calculated for the pretest and posttest groups, and an independent *t*-test was conducted to establish whether any statistically significant differences existed between the groups.

Results

As was expected, there was a positive increase in knowledge gained by the subjects following the peer-led AIDS presentation. The mean score for the pretest questionnaires was 111.17 (N=41, SD=7.829). The mean score for the posttest questionnaire was 118.293 (N=41, SD=7.339). Table one shows the comparison of mean

scores from pretest to posttest. The results of a two-tailed, independent t-test suggest that the participants had a significantly increased knowledge of HIV/AIDS following the presentation (t=-4.25, df=80, p<.001).

Discussion, Conclusions and Recommendations

The evaluation results supported the hypothesis that the peer led intervention would significantly increase the HIV/AIDS knowledge of the student group.

One weakness of the study was the fact that the pretest and posttest questionnaires were not coded in such a way that would have allowed for a paired t-test analysis. However, results of an independent t-test are usually less significant than a paired t-test, so due to the high significant level obtained, it can be assumed that a strong positive gain would still have been evident.

A second weakness of the study was found in the demographic data of the population sample. Although the psychology class was randomly selected from 14 sections, the age range of over 25 years of age (19 subjects) was extremely high for the traditional undergraduate population. This may be explained due to the fact that the class which was randomly chosen happened to be a night class, which is frequently made up of nontraditional students.

Finally, due to the limitation of time, the study did not assess overt behavior change, or potential decay of knowledge over time. However, enhancing knowledge about AIDS and positive beliefs about preventing AIDS have been primary goals of most

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intervention programs and knowledge is considered an important prerequisite of behavior change (Di Clemente, 1989).

Because changes in HIV/AIDS related knowledge are attributed to the PHF presentations, it would be expected that the peer intervention would generalize to other demographically similar university settings. In addition, while this relatively efficient intervention indicated that changes can occur over a brief period of time, longer interventions may lead to even greater changes. The significant increase of knowledge demonstrated the need for factual information to replace myths, particularly those generated by fear, ignorance, or denial.

The results of the study justify the continued use of PHF's as HIV/AIDS educators in institutions of higher learning. In fact, because many students are already sexually active before entering college, it is recommended that peer-led interventions be implemented in secondary school levels as well.

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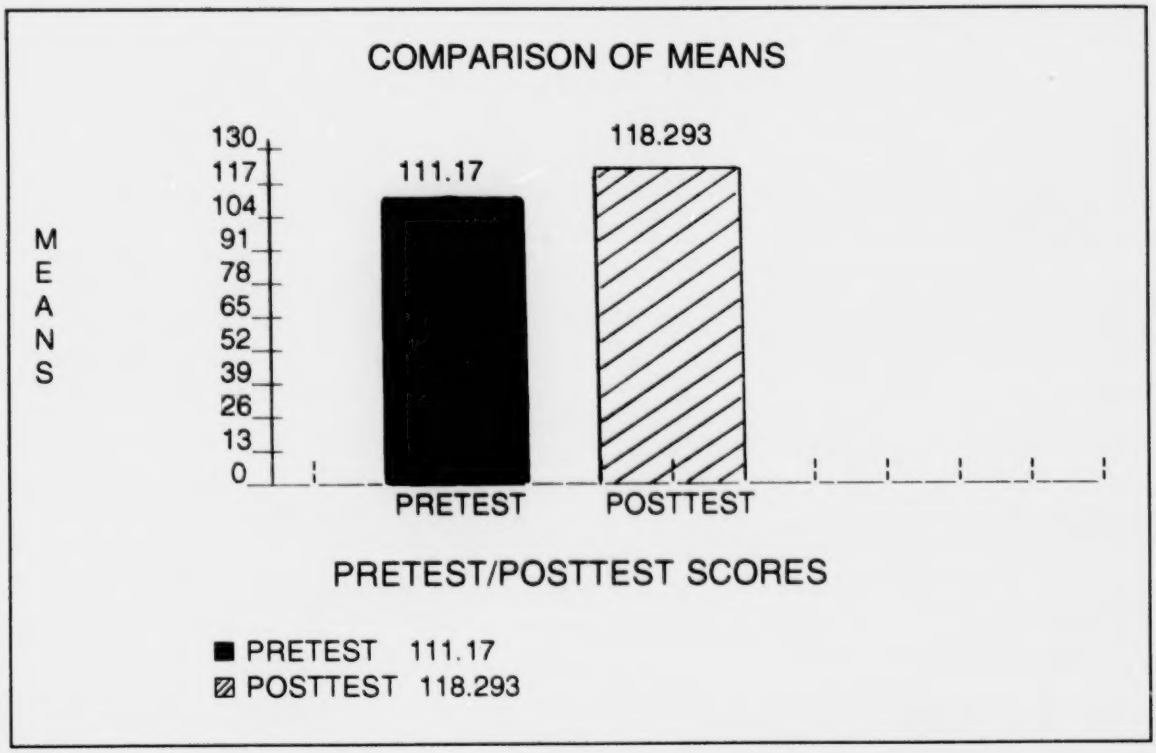
Table 1: Comparison of Pretest/Posttest Means



APPENDIX A

HIV/AIDS FLIP CHART OUTLINE

1. PEER HEALTH FACILITATOR

   I
   V
   /
   A
   I
   D
   S

2. WHY LEARN ABOUT HIV/AIDS?

   History
   - 1981 First case reported
   - 1982 Condition became referred to as AIDS
   - 1983 Virus identified as HIV
   - 1985 ELISA test developed/blood supply tested

   Statistics

   Tip of the Iceberg

1st 100,000 8 yrs.
2nd 100,000 2 yrs.

Stats from 1/93 CDC

AIDS U.S.	242,146
AIDS IN	1,788
HIV IN	2,132
AIDS VIGO CO	42
HIV VIGO CO	100

PROJECTIONS: HIV U.S. 1,500,000
HIV IN 19,000
HIV ON CAMPUS 2-3 PER 1,000 STUDENTS
(ACHA study of 1985)

3. HIV: Human Immunodeficiency Virus

   How does HIV affect the immune system?

   Virus destroys immune system cells that normally protect against invaders

4. STAGES OF HIV INFECTION/PROGRESSION

   days 5-10 yrs. months/yrs. AIDS

   1. Initial infection with possible flu-like symptoms
   2. Asymptomatic-no illness apparent
   3. Symptoms develop as immune system deteriorates (chronic diarrhea, cough, night sweats, weight loss, fatigue, fever, swollen lymph glands, etc.)
   4. Immune system depleted, opportunistic infections invade the body-AIDS

5. AIDS: Acquired Immuno Deficiency Syndrome

*Diagnosis made when opportunistic infections are present
*Most common infections:
Pneumocystic Carinii Pneumonia (PCP)
Kaposis Sarcoma (cancer-purple spots on body)
Thrush (yeast infection in genitals, mouth, throat and lungs)
Dementia (like Alzheimer's)
Brain Tumors
STD's

6. MODES OF TRANSMISSION:

a. Exchange of body fluids (blood, semen, vaginal fluids) through unprotected sex with an infected partner

ANAL
VAGINAL MAN To MAN, MAN To WOMAN or WOMAN To WOMAN
ORAL

b. Blood to blood contact

-Sharing contaminated needles/syringes (intravenous drug use, tatoos, piercing body parts, etc.) (HIV can live in dried blood for a period of time)

-Blood transfusions, clotting agents, organ transplants

Blood has been tested since March, 1985 but is still not 100% safe due to WINDOW PERIOD: the time it takes for HIV antibodies to appear on the test (6 months or more)

c. Mother to child

-Through pregnancy, childbirth, and in a few cases through breastfeeding

d. 3 CONDITIONS MUST BE PRESENT FOR TRANSMISSION:
1. One partner must be infected
2. There must be enough of the virus present to be transmitted
3. Must be a mode of transmission

7. MYTHS & INCORRECT PERCEPTIONS

*HIV is not transmitted through casual contact!
(touching, hugging, dry kissing, towels, toilets, dishes, phones, pools, tubs, mosquitoes, sneezes, tears, saliva)

*You cannot get HIV from just being around someone with HIV!

8. IT'S NOT WHO YOU ARE - BUT WHAT YOU DO
- Anyone who practices unsafe sexual behaviors is at risk for HIV infection.

9. PROTECTION/PREVENTION

*Abstinence (no sex)
*Mutually Monogamous Relationship
*If you do share needles, clean twice with bleach, twice with water
*Be aware of influencing factors (alcohol & drugs)
*Talk to your partner about your concerns
*Be responsible for yourself
*Practice safer sex

9. SAFER SEX

-Safer sex is any activity that does not involve the exchange of semen, vaginal fluids or blood.

i.e.: Touching, hugging, massaging, bathing together, dry kissing, phone sex, masturbation, mutual masturbation, etc.

10. IF YOU HAVE SEX, USING CONDOMS GREATLY LOWERS YOUR RISK OF INFECTION.

USE A LATEX CONDOM AND NONOXYNOL 9 SPERMICIDE, EVERY TIME, FROM START TO FINISH, UNLESS YOU KNOW YOUR PARTNER DOES NOT HAVE HIV.

11. CONDOMS

DO	DON'T
Latex	Sheepskin
Check expiration date	Use expired ones
Water based lubricant	Oil based lubricant
Reservoir tip	Forget to leave space at tip
Carry at all times	Store in wallet for extended period of time

12. TESTING

-The only way to know for sure is to be tested

TESTS: ELISA
WESTERN BLOT

-Types of sites:

CONFIDENTIAL (use your real name, can be accessed by employer or insurance)

ANONYMOUS (fictitious name or code number)

13. Remember: You are the only one who can protect yourself from HIV/AIDS.

Take the responsibility to save your own life!

14. RESOURCES

Julie Miller, SHP
Coordinator of Sexuality Education
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Planned Parenthood
Cherry Street Clinic
Anonymous/Confidential Testing Site
Sliding Scale Fee Structure
238-2636

Anonymous Testing also available at:
Bloomington Mental Health Center
Indinapolis Bell Flower Clinic

15. Visits to ISU Health Center related to treatment of Sexually Transmitted Diseases:

	7/1/90 to 6/28/91	7/1/91 to 6/30/92
Total pts. seen:	(22,758)	(21,638)
Genital Herpes	32	38
Gonorrhea	46	52
HPV (Genital Warts)	481	412
Nongonococal Urethritis	99	88
Trichomoniasis	20	23
Chlamydia	70	116

16. Contraceptives:

	Effectiveness as Birth Control	Protection From HIV/STD's
Birth Control Pills	97%	None
Norplant	99.8%	None
IUD	97%	None
Diaphragm/Cervical Cap	80%	Some
Condoms Alone	88%	Some
Condoms with Nonoxynol 9	99%	Most
Spermicide Alone	80%	Some
Contraceptive Sponge	82%	Some
Female who's given birth:	72%	Some

APPENDIX B

STD SHUFFLE

MATERIALS NEEDED:
Blank index cards
Index card with *
Index cards with instructions:
a. Please do not shake hands with anyone during this exercise. You may introduce yourself and sign their card, but do not shake their hand.
b. Please wear the latex glove for duration of the exercise.
c. Please only shake hands with the person seated to your direct left.
d. Please only shake hands with the person seated to your direct right.
Latex glove (2 for large groups)
Instruction cue-card for yourself

DIRECTIONS:
1. **Do not** tell students the name of the exercise until the end. Simply tell them you'd like them to all participate in an icebreaker exercise.

2. Distribute index cards to all students. Be sure to give out * card, and cards with condom, mutually monogamous relationship and abstinence directions. Give glove to person as you give them the corresponding card. Make sure the persons receiving the monogamous relationship cards are seated right next to each other and hold the left card in your left hand, the right card in your right hand, so the couple is only shaking hands with each other and not with the people on the other side of them, which would make this part of the game void.

3. Tell students who have directions on their card to please follow directions, but not to share the information with others.

4. Tell students they have 2-3 minutes to get up, introduce themselves to 5 students, shaking hands with each one and writing that person's name on their card as they are introduced. After they have received signatures and shaken hands with 5 persons, they may be seated. (The # of people they shake hands with can be adjusted according to the number of people present.)

5. Once students are seated, ask person whose card has a * in right hand corner to stand. For purpose of this exercise, this person has a STD (or HIV). For the purpose of exercise, shaking hands signified having sexual intercourse. Ask * person to read names on his/her card and those people are to stand. Have those persons read names on their cards and have those persons stand. Continue reading names and having people stand until all persons are standing.

6. All persons standing have been exposed to STD (or HIV), but following people may sit: person with glove, which signified condom use; person who did not shake hands, which signified abstinence;

and the persons who only shook the hand of the person seated on their left and right, which signified a mutually monogamous relationship.

7. The rest of the group was exposed, and is at risk of having a STD (or HIV).

8. Rest of group may now be seated and you will ask the following questions:

Condom Wearer: How did it feel to wear glove during exercise? Did people shun you?

Whole Group: Did you mind shaking hands with glove wearer? Did you refuse to shake their hand? (Correlate glove with condom, how people often don't use condom because they fear rejection from partner and note that the glove did not keep people from shaking hands)

Abstainer: How did it feel to not shake hands? Did you feel left out? Feel need to give in to peer pressure?

Whole Group: Were you upset that the abstainer did not shake your hand? Did you refuse to meet them if they wouldn't wouldn't shake your hand? (Note that practicing safer sex does not have to alienate people, they can still date and have relationship without having sexual intercourse)

Monogamous: Were you truly monogamous? (Usually these directions are most frequently not followed and one or more of the persons is unfaithful) Was it hard to be in a relationship with only one person? If you strayed, why?

Whole Group: Relate how difficult it is to know for sure if you are really in a monogamous relationship. We can o only be sure of our own behavior, we can never be sure of our partners'.

Whole Group: How did you feel toward the person who had exposed you to a STD? Angry? Distrust?

STD Person: How did you feel? Like a victim too?

Whole Group: Emphasize the fact that although people tend to blame the person who has exposed them to a STD or HIV, everyone is responsible as we have to take responsibility for ourselves. Sometimes it is much easier to blame than to take responsibility.

9. Emphasize that shaking hands does not spread HIV or STD's and was just used for the purpose of this exercise to show how quickly STD's can be spread among sexually active persons (especially those with multiple partners).

APPENDIX C

KNOWLEDGE/ATTITUDES ABOUT HIV/AIDS
PRE-TEST
POST-TEST

Directions: Read each question/statement carefully. Select the response which most nearly reflects your understanding/attitude.

1. Year in school:
   a. freshman b. sophomore c. junior d. senior e. other

2. Gender:
   a. female b. male

3. Age:
   a. 17-18 b. 19-20 c. 21-22 d. 23-24 e. 25 or more

4. Which of the following describes your relationship status at this time?
   a. I am in a primary relationship where we live together.
   b. I am in a primary relationship where we date, but do not liye together
   c. I am not in a primary relationship but I do date.
   d. I am not in a primary relationship but I do not date.
   e. Other (explain):_____

_____

RESPOND TO THE FOLLOWING STATEMENTS USING THE FOUR POINT SCALE WHICH FOLLOWS:

a. Definitely true
b. Probably true
c. Probably false
d. Definitely false

___ 5. Anyone who has unsafe sex or shares needles with an infected person can become infected with the HIV.

___ 6. An experienced person can look at someone and tell if he/she is infected with the virus that causes AIDS.

___ 7. You can protect yourself from becoming infected with the HIV.

___ 8. There is a cure for AIDS.

THE HIV CAN BE TRANSMITTED BY:

___ 9. anal intercourse, from man to man, without using a condom.

___ 10. vaginal intercourse, from man to woman, without using a condom.

___ 11. oral sex, from woman to woman, without using protection.

___ 12. vaginal intercourse, from woman to man, without using a condom.

___ 13. anal intercourse, from man to woman, without using a condom.

___ 14. kissing on the mouth.

___ 15. giving blood

___ 16. being bitten by mosquitoes or other insects.

___ 17. having a blood test.

___ 18. sitting on a public toilet seat

___ 19. sweat

___ 20. saliva

___ 21. tears

___ 22. sneezing or coughing

___ 20. sharing needles or syringes.

PEOPLE CAN REDUCE THEIR CHANCES OF BECOMING INFECTED WITH THE HIV BY:

___21. not having sexual intercourse (being abstinent).

___22. using latex condoms (rubbers) during sexual intercourse.

___23. urinating after sexual intercourse.

___24. having sexual intercourse only with a person who is not infected with the HIV.

___25. not having sexual intercourse with a person who uses illegal drugs that are injected.

___26. using a birth control pill (oral contraceptive).

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RESPOND TO EACH OF THE FOLLOWING STATEMENTS BY USING THE FOUR POINT SCALE WHICH FOLLOWS:

a. strongly agree
b. agree
c. disagree
d. strongly disagree

___27. I know where in my community I can receive accurate information about HIV/AIDS.

___28. I know where in my community I could receive a blood test to determine whether or not I had been exposed to the HIV.

___29. I know where in my community I could find a support group for a friend who was HIV positive.

___30. Even if I don't protect myself during sex, there really is practically no chance I could contract the HIV.

___31. There is a chance that I have already been infected with the HIV.

___32. Very few students are doing anything differently because of AIDS.

___33. A pregnant woman who is HIV positive can infect her unborn baby with the virus.

___34. The idea of getting AIDS really frightens me.

___35. People get AIDS only if they perform unnatural acts.

___36. People who are HIV positive should not be permitted to attend classes in order to protect others from acquiring the virus.

___37. It is unlikely that an effective vaccine or cure for AIDS will be found in this century.

___38. Everyone should be tested for the HIV antibody.

___39. It is within my power to protect myself from being exposed to the HIV.

___40. HIV/AIDS is not really a problem on this campus.